Members of the Legislative Assembly

Benefit Guide

For Members of the Legislative Assembly

Yukon
Public Service Commission

Members of the Legislative Assembly (MLAs)

Benefit Booklet

This *Guide* provides information on the Government of Yukon Public Service Group Insurance Benefits for Members of the Legislative Assembly. The contents are designed to inform MLAs of Plan details. Every effort has been made to ensure that the information presented is accurate. However, if there is a question of interpretation about the information presented in this *Guide*, the official benefit plan documents, insurance contracts and any legislated requirements will prevail. The Government of Yukon expects and intends to keep the benefit program in force indefinitely, but reserves the right to modify, revoke, suspend, terminate or change the Plans, in whole or in part, at any time.

About Your Benefit Guide

This *Benefit Guide* is your reference tool, designed to help you understand your benefit coverage. We encourage you to keep it handy for future reference.

To make it easy for you to navigate this *Guide*, the following handy features will help you find the information you need quickly.

These features include:

- **What's Inside** – a comprehensive table of contents to help you navigate the *Guide*
- **Overview** – highlights of your complete Benefit Plan
- **Benefits at-a-Glance** – a quick overview of your benefits and reimbursement percentages
- **Reference Points and Questions & Answers** – important information and answers to commonly asked questions placed throughout the text for easy reference
- **Glossary of Terms** – important terms and their meanings
- **Who to Call** – who you should call if you have questions

We encourage you to refer to this *Guide* whenever you have a question about your benefits. If you have questions that aren't answered here, or need clarification on a particular coverage, please contact the Public Service Commission.

What's Inside?

Overview

Your benefits are an important component of your total compensation. As well, they are critical protection for you and your family in a variety of situations – those we all want to avoid, such as serious illness or death, and those that are more commonplace such as the need for a prescription or a dental checkup.

The Benefit Plan provides you and/or your dependent(s) with the following benefits:

- Extended Health Care Plan
  - → Single
  - → Dependent(s)
- Dental Plan
  - → Single
  - → Dependent(s)
- Life Insurance
  - → Basic
  - → Optional
  - → Dependent(s)
- Accidental Death & Dismemberment (AD&D) Insurance
  - → Basic
  - → Dependent(s)
- Long Term Disability (LTD)

Keep in Mind:

The Benefit Plan provides you and/or your dependent(s) with the following benefits:

- → Extended Health Care Plan
- → Dental Plan
- → Life Insurance
- → Accidental Death & Dismemberment (AD&D) Insurance
- → Long Term Disability (LTD)

Benefits at-a-Glance

Extended Health Care

	Coverage
Deductible	
• Prescription Drugs	$6.00 per prescription*
• All Other Expenses	None
Coinsurance	
• Drug Benefit	80%
• Vision Care	80%
• Miscellaneous Health Care	80%
• Hospital Benefit	100%
• Travel Assistance	100%
• Out-of-Province Referral	80%
Vision Care Benefit	
• Eye glasses / contact lenses	$200 per two benefit years
Hospital Benefit	Semi-private accommodation
Travel Assistance Coverage	$1,000,000 per lifetime (maximum 60 days for each period of travel)
Out-of-Province Referral	$50,000 per lifetime
Paramedical Practitioners	
• Acupuncturist, Chiropodist, Chiropractor, Massage Therapist, Naturopath, Osteopath, Physiotherapist, Podiatrist, Speech Language Pathologist	Combined maximum of $1,000 per benefit year for all practitioners (except psychologist)
• Psychologist	$1,000/benefit year
Nursing Services	$25,000/three benefit years
Orthopedic Shoes	$150/benefit year
Orthotics	$150/benefit year
Hearing Aids	$600/five benefit years
Orthopedic Brassieres	Two per benefit year
Wigs	$300/benefit year

* The per prescription deductible also applies to certain non-prescription items covered under the Drug Benefit.

Dental Care

	Coverage
Deductible	$50 Single / $75 Family*
Coinsurance	
• Diagnostic/Preventive	100%
• Restorative	100%
• Orthodontic	50%
• Periodontic	100%
• Denture	50%
• Bridge	50%
• Crown	50%
• Endodontic	100%
Maximum	$1,000 per benefit year for all expenses combined except for Orthodontic $2,000 lifetime for Orthodontic (Dependent children only)

* The deductible does not apply to Orthodontic services

Benefits at-a-Glance, continued

Life Insurance

	Benefit amount
Basic	One time annual earnings Reduces by 50% at age 65
Optional	One time annual earnings Reduces by 50% at age 65
Dependent(s)	Spouse: $5,000 Each Child: $2,500

Accidental Death & Dismemberment (AD&D) Insurance

	Benefit amount
MLA	Units of $25,000 to a maximum benefit of $250,000
Dependent(s)	Spouse: $5,000 Each Child: $2,500

Long Term Disability (LTD)

	Benefit amount
MLA	Effective starting after 13 consecutive weeks of disability 70% of monthly earnings Maximum of $11,000/month

Eligibility

You are eligible to participate in the Government of Yukon Benefit Plan if you are:

- An active member of the Legislative Assembly of the Government of Yukon

Waiting Periods

There is a three-month waiting period for Extended Health Care Plan and Dental Plan benefits if your initial term is greater than six months. There is a six-month waiting period for Extended Health Care Plan and Dental Plan benefits if your initial term is six months or less.

There is no waiting period for the following benefits:

- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Long Term Disability (LTD)

In addition to providing coverage for you, the Benefit Plan will also protect your dependents for Extended Health and Dental. By definition, your dependents include:

- Your spouse, of either sex, either legally married or living common-law for at least one year immediately before application for coverage under the plan
- Your unmarried, dependent children (natural, adopted or stepchild of you or your spouse or a child whom you or your spouse is the legal guardian and the guardianship is court ordered) under age 21, or under age 25 if attending an accredited post-secondary institute, college or university on a full-time basis
- Your physically or mentally disabled children are covered with no age restriction provided they are entirely dependent on you for support and their disability occurred while covered under the Plan as a dependent child

Keep in Mind:

There is no waiting period for Life and AD&D Insurance or LTD; however, for most MLAs there is a three-month waiting period for Extended Health Care Plan and Dental Plan benefits.

Q Do I have to participate in all benefits?

A You must participate, if you are eligible, in the Extended Health Care and Dental coverage. However, Basic Life Insurance, Accidental Death & Dismemberment (AD&D) Insurance, Dependent Life Insurance, Optional Life Insurance and Long Term Disability (LTD) Insurance are not compulsory. Note that LTD Insurance will become mandatory following the next territorial election and the Extended Health Care Plan is not compulsory for MLAs appointed prior to May 1, 2004.

Q What happens if I have comparable coverage under my spouse's benefit plan?

A If you or your dependents have coverage under another plan (i.e., your spouse's), you may decline coverage for your dependents under the Extended Health Care Plan and Dental Plan. For MLAs appointed on or after May 1, 2004, you cannot decline coverage for yourself under these Plans. You are not required to participate in the Extended Health Care Plan if your date of appointment is before May 1, 2004.

Enrollment

Enrolling in the Benefit Plan is simple. Complete the enrollment form(s) supplied to you and forward them to the Public Service Commission for processing.

Step 1: Read

Read all of the information provided in this *Benefit Guide*. If you have questions as you go through the material, please contact the Public Service Commission.

Step 2: Complete

Complete the enrollment form(s), including beneficiary information for life insurance benefits.

Step 3: Submit

Submit your completed enrollment form(s) to the Public Service Commission. Please ensure your forms are complete, signed in ink and dated.

How Much Does it Cost?

Some of your benefits are cost-shared between the Government of Yukon and yourself and others are paid by you through payroll deduction. The value of a group plan like this one is that, typically, the premiums are lower than if you shopped individually for these benefits.

As an MLA, the premiums for your Extended Health Care, Dental and Long Term Disability are 90% covered by the Government of Yukon; you pay the remaining 10%. The premiums for your Basic Life Insurance, Optional Life Insurance, AD&D, Dependent Life and Dependent AD&D are 100% paid by you through payroll deduction. Information on current premium rates is available from the Public Service Commission.

Making Changes

In order to have your coverage updated, please notify the Public Service Commission about any of the following life events:

- Marriage/Common-law relationships
- Birth/adoption of a child
- Divorce
- Loss or gain of spouse's employer coverage
- Death of a dependent

Effective Date of Coverage and Rules for Updating Your Coverage

Extended Health Care and Dental Plans

The effective date of your coverage is the first day of the month following completion of the waiting period.

If you apply for dependent coverage within 60 days of your eligibility, then the effective date of coverage for your dependents is the first day of the month following completion of the waiting period (the same date that your coverage begins). If you apply for dependent coverage after 60 days of your eligibility, then the effective date of coverage for your dependents is the first day of the fourth month following the month in which the application is received by the Public Service Commission.

If you waive coverage for your dependents upon appointment as an MLA because they have coverage elsewhere (i.e., through a spousal plan), and that coverage subsequently terminates, you have 60 days to apply for coverage under this Benefit Plan. This 60 day limit also applies in the case of acquiring a new dependent. If your application for coverage is received within 60 days, coverage begins on the day following the date that your dependents' comparable coverage terminated, or the date you acquire a new dependent. If your application for coverage is received after 60 days, coverage is effective on the first day of the fourth month following the month in which the application is received.

If you request a change in coverage from Family to Single, the change is effective on the first day of the month following the date the notice of change is received.

Basic Life Insurance/AD&D/LTD

You have up to 60 days after your date of appointment to apply for Basic Life Insurance, AD&D and LTD coverage. If you apply for coverage more than 60 days after your date of appointment, you will be required to provide *Medical Evidence of Insurability*. In order to participate in the AD&D Plan, you must enrol in the Basic Life Insurance Plan.

Following the next territorial election, LTD insurance will become mandatory and if eligible, you will automatically be enrolled in the LTD Plan.

Optional Life Insurance

If you choose to elect Optional Life Insurance, you are required to submit *Medical Evidence of Insurability*. Coverage is not effective until your application has been received and approved by the insurance company. In order to participate in the Optional Life Insurance Plan, you must enrol in the Basic Life Insurance Plan.

Dependent Life Insurance/Dependent AD&D

You have up to 60 days after your date of appointment to apply for coverage for dependents, otherwise coverage will require *Medical Evidence of Insurability*. In order to participate in the Dependent Life/AD&D Plan, you must enrol in the Basic Life Insurance Plan.

Q What is *Medical Evidence of Insurability*?

A *Medical Evidence of Insurability* is proof of good health. Typically, you fill out a form and answer a number of medical questions to provide proof of your or your dependent's physical condition. Providing medical evidence may be mandatory before your application for coverage is considered.

Yukon Health Care Insurance Plan

Your Extended Health Care Plan covers health services and supplies over and above what is provided by the Yukon Health Care Insurance Plan. The Territory pays for many basic medical expenses for residents of the Yukon, such as:

- Doctors' and surgeons' fees
- Specialists' fees when referred by a general practitioner
- Diagnostic procedures, including x-ray and lab tests
- Maternity care
- Standard ward hospital accommodation
- Outpatient treatment

For more information about eligible expenses, contact your local Yukon Health Care Insurance Plan office.

Q What is the difference between the Extended Health Care Plan and the Yukon Health Care Insurance Plan?

A Yukon Health Care Insurance is the mandatory health insurance plan sponsored by the Territory for residents of the Yukon. It pays for basic medical services, such as doctors' fees and standard ward hospital accommodation. The Extended Health Care Plan is a private health service plan sponsored by the Government of Yukon for MLAs. The Extended Health Care Plan provides reimbursement for many expenses, such as prescription drugs, paramedical services, and other services, not covered by the Yukon Health Care Insurance Plan.

Claims Procedures

Extended Health Care Plan

For prescription drugs, show the pharmacist your Pay Direct Drug Card and your claim will be processed electronically. If your prescription drug claim is not adjudicated electronically, you need to submit a paper claim form.

For all other Extended Health Care claims, claim forms are available from the Public Service Commission, or you may print a claim form off of the insurer's website or the Public Service Commission website. You have 18 months from the date you incurred the expense to claim for reimbursement (90 days if your coverage is terminated). Simply fill out the form, attach the original receipts and send it to the insurance company for reimbursement. It's always a good idea to keep a copy of your claim form and receipts for your records.

Q What is a Pay Direct Drug Card?

A For convenience, the insurance company supplies you with a drug card to speed up expense claims processing for prescription drugs. When you have a prescription filled, your pharmacist will use your card to electronically process your prescription expense claim on the spot. You must pay whatever balance is owing once your eligible expense amount has been deducted. (*See Extended Health Care Plan – Prescription Drugs* for more information.)

Dental Plan

For Dental Plan claims, you must pay your dentist directly for services received, then submit a claim to the insurance company for reimbursement. Standard Dental claim forms can be obtained from your dentist, or from the insurer's website or the Public Service Commission website. You have 18 months from the date you incurred the expense to submit a claim (90 days if your coverage is terminated). Remember to attach original receipts to your claim and keep a copy of the claim and receipts for your records.

Coordination of Benefits

If you and your spouse are separately insured for dependent Extended Health Care and/or Dental coverage, you may be eligible for reimbursement up to 100% for some of these expenses, by submitting your claims each in turn to your respective insurance companies, as follows:

If you have incurred the expenses, you first submit your claim to your insurance company. Once they've processed your claim, your spouse submits the remaining expense noted on the statement of payment to his/her insurance company, including the following documents:

- A copy of the claim submitted to the first insurance company, and
- A copy of all receipts, and
- A copy of reimbursement details, or refusal, from the first insurance company.

If your spouse incurred the expenses, your spouse will submit the claim first to his or her insurance company and then to your Benefit Plan.

For expenses incurred for a dependent child, the claim must first be submitted by the parent whose birth date is first in the calendar year. If an expense is not completely paid, the remaining amount can be submitted to the spouse's plan. The documents listed above must always accompany the second claim.

For prescription drugs, the process is a little different because your Plan includes a *Pay Direct Drug Card*. You use your drug card to process a prescription for yourself or your dependents (if your birth date is first in the year). If there is a balance remaining once the pharmacist has processed your prescription, you pay it, and then submit the receipts to your spouse's insurance company for reimbursement. (*See Extended Health Care Plan– Prescription Drugs* for more information.) If your spouse's plan also has a drug card, you may be able to process both claims at once. Simply tell your pharmacist which drug card to use first to process the claim. This capability may not be available in all pharmacies or with all insurance companies.

Q Does co-ordination of benefits apply if my spouse and I are both covered under the Government of Yukon's Benefit Plan?

A Yes, coordination of benefits still applies, and the process for reimbursement is the same too, as if you were insured by two different insurance companies.

Keep in Mind:

Remember by coordinating benefits with your spouse's benefit plan, you may be reimbursed for up to 100% of your Extended Health Care and Dental Care plan costs.

Life Insurance

Life Insurance claims must be submitted to the insurance company within six years of the death of an MLA. Basic and Optional Life Insurance benefits are paid to the beneficiary, or the estate, if no beneficiary has been designated. Beneficiaries have a choice as to whether they wish to receive a lump sum, or regular payments, in the form of an annuity (unless the form of payment has been stipulated during enrollment). In the case of the estate receiving the benefit, a lump-sum payment is issued. The claimant must submit proof of the claim and the right to receive the benefit. The insurance company may request additional information, at their discretion. For more information, contact the Public Service Commission.

Life Waiver of Premium claims are submitted to the insurance company in conjunction with your Long Term Disability claim. An explanation of Life Waiver of Premium can be found in the Life Insurance section of this *Guide*.

Dependent Life Insurance claims must be submitted to the insurance company within six years of the death of a dependent. Benefits are paid to you in the form of a lump sum payment. The claimant must submit proof of the claim and the right to receive the benefit. The insurance company may request additional information, at their discretion. For more information, contact the Public Service Commission.

Accidental Death & Dismemberment (AD&D) Insurance

AD&D Insurance provides financial protection for expenses arising from a death, or loss, due to an accident. Depending on the circumstances, the claim procedures are as follows:

For the death of an MLA or dependent: Claims must be submitted to the insurance company within six years of the death. You or your dependents must have been covered under the Benefit Plan when the accident occurred. You are the beneficiary for dependent claims. Claims submitted for an MLA will be issued to the beneficiary, or the estate, if no beneficiary has been designated.

For a loss by an MLA or dependent: Claims must be submitted to the insurance company within three months of the date of the loss. You or your dependents must have been covered under the Benefit Plan when the accident occurred, and the loss must have occurred within 365 days of the accident. Benefits are payable to the MLA, if alive, or to the beneficiary or estate if the MLA has died.

The claimant must submit proof of the claim and the right to receive the benefit. The insurance company may request additional information, at their discretion. For more information, contact the Public Service Commission.

Long Term Disability (LTD)

Long Term Disability (LTD) benefits take effect after a qualifying period of 13 weeks of continuous disability. Claims must be received within three months of the end of the qualifying period. Proof that you are totally disabled, an examination by an independent physician, a vocational or functional capabilities assessment, or other information the insurance company may consider necessary may have to accompany your claim. For more information, contact the Public Service Commission.

Keep in Mind:

The qualifying period is that period of time when you are continuously disabled but not yet eligible to receive LTD benefits (sometimes referred to as "elimination period"). This period lasts for 13 weeks of continuous disability.

Q Are there time restrictions on filing claims?

A Yes, and they vary, depending on the benefit. Following are the time restrictions on filing claims for each Plan:

- Extended Health Care: 18 months from the date the expense is incurred. However, if your coverage has terminated, you have 90 days from the date of termination to submit outstanding expenses.
- Dental: 18 months from the date the expense is incurred. However, if your coverage has terminated, you have 90 days from the date of termination to submit outstanding expenses.
- Life Insurance: six years from the date of death
- Accidental Death and Dismemberment (AD&D) Insurance: six years from the date of death for death claims, three months from the date of loss for loss claims
- Long Term Disability (LTD): three months from the end of the qualifying period

Termination of Coverage

There are a number of reasons your coverage could be terminated:

- You are no longer eligible (i.e., you are no longer an active MLA), or
- You fail to pay your portion of the premiums, where applicable, or
- You reach termination age (i.e., age 65 for Long Term Disability), or
- You retire

Extended Health Care Plan

The Extended Health Care Plan provides you and your dependents with coverage for medically-necessary expenses over and above those covered by the Yukon Health Care Insurance Plan.

Q What does *medically necessary* mean?

A Medically necessary is defined as services and supplies generally recognized by the Canadian medical profession as effective, appropriate, and required in the treatment of an illness in accordance with Canadian medical standards.

Expenses are reimbursed at the levels indicated in the following chart; however, there are certain limitations and exclusions (see *Limitations and Exclusions* at the end of this section). For prescription drugs, there is a deductible of $6.00 per prescription. There is no deductible for other Extended Health Care expenses. If applicable, after you have paid the deductible, you are reimbursed by the insurance company for the balance of your costs, up to the limit that the Plan covers for *reasonable and customary* charges.

Extended Health Care (single dependent(s))	Reimbursement Level
Prescription Drugs (drug card)	80%
Vision Care	80%
Miscellaneous Supplies/Services (i.e., massage therapist, hearing aids)	80%
Hospitalization	100%
Travel Assistance (i.e., within Canada and out-of-country)	100%
Out-of-Province Referral	80%

Q Why is there a deductible?

A Deductibles are one way of sharing the total cost of benefits between MLAs and the Government of Yukon. For each prescription drug you purchase, you must pay a $6.00 deductible. The remaining eligible amount is then reimbursed according to the provisions of the Plan.

Q What are *reasonable and customary* charges?

A *Reasonable and customary* charges are those that are normally made to people in the area where the expense is incurred. The insurance company will determine if the charge is *reasonable and customary*.

Keep in Mind:

Remember, by coordinating benefits with your spouse's benefit plan, you may be reimbursed for 100% of your Extended Health Care costs.

Q What happens if I leave the country for an extended period of time (e.g., for 12 months or longer)?

A You will need to contact both the Yukon Health Care Insurance Plan and the Public Service Commission to discuss your ability to continue coverage under this Plan. If coverage under the Yukon Health Care Insurance Plan terminates, then you will no longer be eligible for coverage under the Extended Health Care Plan.

Prescription Drugs

The Plan offers extensive prescription drug coverage for you and your eligible dependents. The plan includes a $6.00 per prescription deductible and reimburses you for 80% of the cost of drugs according to a drug listing called a *frozen formulary*. Here's how it works:

- As of December 31, 2001 the listing of drugs eligible under the plan was frozen. This means that any drug covered by the plan – generic or brand name – as of that date will continue to be covered under the plan.
- As new drugs are developed and introduced, they will be reviewed by an independent medical panel to determine if they should be added to the formulary. In conducting their review, the panel considers whether or not the drug provides a significantly better or different result than other treatments available or if in fact the drug could be considered a *breakthrough drug*, offering treatment for illnesses or conditions for which no other therapies are available.
- If the panel feels the drug is a breakthrough drug or provides significantly better or different results, the drug will be added to the list and is eligible for reimbursement under the plan.
- If the drug is not deemed to provide a significantly different benefit than other available therapies, it will not be added to the listing and is therefore not eligible for expense reimbursement.
- If you choose to purchase a drug not on the frozen formulary listing, you will be responsible for the entire cost of the drug.

The Plan includes mandatory generic substitution, where a generic drug exists, unless your Physician specifies "no substitution" on the prescription. If a brand name drug is purchased and the Physician has not specified "no substitution", then reimbursement will be made based on the lower cost generic drug.

Q Which drugs qualify as prescription drugs under the Plan?

A Drugs bearing a Drug Identification Number (DIN), legally requiring a written prescription from a physician or dentist and dispensed by a pharmacist. In addition, the drug must be listed as an eligible prescription drug on the Plan's formulary. Vaccines are covered whether or not they legally require a written prescription and are not limited to the frozen formulary.

If you have any questions regarding the eligibility of prescription drugs, you can contact your physician, pharmacist or insurer.

You will receive a Pay Direct Drug Card from the insurance company that you can use to get your prescriptions filled with a pharmacist. Instead of having to file a claim for each prescription, the Pay Direct Drug Card allows the pharmacist to electronically process your claim for you.

You are only required to pay the pharmacist the balance of what the insurance company did not cover. If you are coordinating benefits with a spouse's plan, you would submit the receipt for any remaining expense to your spouse's insurance company for reimbursement.

What is Covered

In addition to drugs bearing a DIN, the Plan also covers expenses for:

- Non-prescription drugs and supplies which are considered life sustaining (i.e., drugs required for the treatment of cystic fibrosis, diabetes, or Parkinson's disease)
- Drugs which may not require a prescription, but that the insurance company considers therapeutic
- Injectible drugs (including allergy serums)
- Supplies used in the treatment of diabetes

These items are also subject to the $6.00 deductible.

What is Not Covered

No benefit is payable for:

- Contraceptives, other than oral
- Dietary supplements, infant food, and sugar or salt substitutes
- Drugs, which, in the insurance company's opinion, are experimental
- Drugs which are used for cosmetic purposes
- Drugs used for the treatment of obesity
- Drugs used as Smoking Cessation Aids
- Drugs used for the treatment of erectile dysfunction
- Lozenges, mouthwashes, contact lens care products, skin cleansers or emollients
- Surgical supplies and diagnostic aids
- Therapeutic nutrients
- Vitamins, minerals and protein supplements

Vision Care

Vision Care covers you and your dependents for the cost of one eye examination every two benefit years. In addition to that, the Benefit Plan reimburses you for the cost of prescription eyeglasses, sunglasses, safety glasses or contact lenses and repairs to them to a maximum limit of $200 per two benefit years (where a benefit year runs from April 1 to March 31). Intraocular contact lenses following cataract surgery are also covered one per eye per lifetime. The reimbursement level for the Vision Care Plan is 80%.

If the eyeglasses or contact lenses are required as a direct result of surgery for the treatment of keratoconus, the maximum does not apply as long as they are purchased within six months of the surgical procedure.

Q Will the Plan pay for multiple vision care claims such as disposable contact lenses?

A Yes it will, but keep in mind that the Plan operates under a two-year benefit period. For instance, if you purchase $50 in disposable contact lenses in June, you would have $150 left for the current benefit year and following benefit year. This amount can be used with one purchase or multiple purchases.

Miscellaneous Supplies/Services

There are a number of other expenses that the Plan covers, such as massage therapy and hearing aids. As long as the expenses are medically necessary, reasonable and customary, and prescribed by a licensed physician (where noted), you may be able to recover some of the costs – up to 80%.

Keep in Mind:

There are a number of other expenses that the Plan covers, such as massage therapy and hearing aids. As long as the expenses are medically necessary, reasonable and customary, and prescribed by a licensed physician (where noted), you may be able to recover some of the costs – up to 80%.

Outlined below are eligible expenses, as well as any limitations or maximums that may apply. This list is not all inclusive; questions regarding the eligibility of a specific service or supply should be directed to the insurance company.

Services

- Dental services, including braces and splints, to repair damage to natural teeth caused by accidental blow to the mouth. Services must be rendered within twelve months of the accident
- Emergency air ambulance
- Ground ambulance services to the nearest hospital
- Paramedical practitioners - $1,000 per benefit year maximum for the following practitioners' services combined:
  - Acupuncture treatments
  - Chiropractor
  - Chiropodist
  - Massage Therapist. Requires a physician's written prescription.
  - Naturopath
  - Osteopath
  - Physiotherapist
  - Podiatrist
  - Speech language pathologist. Requires a physician's written prescription.
- Psychologist ($1,000 per benefit year maximum)..
- Services of a private duty nurse in your home ($25,000 per three benefit years maximum)

Supplies

- Blood glucose monitors ($700 per lifetime maximum)
- Braces, not including anything primarily used for athletic purposes
- Colostomy, ileostomy and tracheostomy supplies, catheters and drainage bags for incontinent patients
- Devices for delivery of asthma medication
- Elastic support stockings, including pressure gradient hose, up to two pairs per benefit year
- External breast prosthesis if required as a result of surgery ($200 per benefit year maximum)
- Hearing aids, including repairs and batteries ($600 per five benefit years maximum)
- Insulin pumps (one pump per 5 benefit years). Requires a physician's written prescription.
- Orthopaedic shoes ($150 per benefit year maximum). Requires a physician's written prescription.

- Orthotics ($150 per benefit year maximum)
- Oxygen and equipment used for its administration
- Rental, or purchase of durable equipment for use in the patient's private residence (i.e., walkers, wheelchair, hospital beds, apnea monitors)
- Surgical or mastectomy brassieres (two per benefit year)
- Temporary/permanent artificial limbs and artificial eyes, including myoelectric appliances where medically necessary
- Trusses, crutches, splints, casts and cervical collars
- Wheelchair repairs ($250 lifetime maximum)
- Wigs, due to hair loss from an illness ($300 per benefit year maximum)

What is Not Covered

No benefit will be payable for:

- Items purchased primarily for athletic use
- Expenses for repair or replacement of purchased durable equipment, other than wheelchair repairs

Hospitalization

The Yukon Health Care Insurance Plan provides some coverage while you are in hospital. Additional coverage is provided by the Extended Health Care Plan. Reasonable and customary charges for semi-private hospital room and board charges are covered up to 100%. Any charges referred to as *co-insurance* or *utilization fees* are not covered.

Out-of-Province Hospitalization

If your physician refers you or your dependents for treatment outside of your home territory or province because specific treatment is not available in your home territory or province, you or your dependents will be covered for Extended Health Care. In addition, you or your dependents will be covered for public ward accommodation and auxiliary hospital services in a general hospital, and physicians' services in excess of the amount payable by the Yukon Health Care Insurance Plan. Reimbursement is set at 80%, and is limited to $50,000 per lifetime.

Travel Assistance

The Extended Health Care Plan also offers 100% coverage for you and your dependents for travel while outside your province or territory on vacation or business. If you are faced with an emergency, for treatment of an injury or disease, you are covered for up to $1,000,000* assuming you are outside your province or territory for less than 60 days.

** Some maximums do apply.*

Keep in Mind:

Traveling Outside Yukon?

- ➔ Review your Travel Assistance benefit.
- ➔ Carry the insurer's emergency travel assistance wallet card with toll free numbers to call in case of a medical emergency.
- ➔ Carry your Pay Direct Drug Card in case you need to purchase prescription drugs. The Pay Direct Drug Card will be accepted at pharmacies within Canada, but not outside Canada.

What is Covered

The Travel Assistance benefit provides:

- Family assistance benefits (i.e., return transportation for dependent children under age 16, costs for a relative to visit, meals and accommodation) up to a maximum of $2,500 per travel emergency
- Medical evacuation to a location with suitable care facilities
- One-way economy airfare for the patient's return home
- Services of a physician
- Ward accommodation in a hospital
- Where necessary, one-way economy airfare for a professional attendant to accompany the patient

A worldwide assistance network is available to you, while travelling, 24 hours a day. By dialing a toll-free number, you can get assistance with:

- Advance payments to a hospital or medical provider
- Interpretation services
- Legal referrals
- Medical referrals, consultations and monitoring
- Messaging services
- Transportation arrangements to the nearest hospital, or back to Canada

What is Not Covered

Emergency travel assistance will not be provided for the following:

- If the emergency occurs more than 60 days after your departure from your home territory or province
- Expenses incurred where you or your dependents are temporarily or permanently residing outside of Canada
- Expenses for regular treatment of an injury or disease that existed prior to your departure
- Expenses in excess of $1,000,000 per person per lifetime

Keep in Mind:

If you are traveling outside the Yukon (or your territory/province of residence) for more than 60 days, you are still covered for the Prescription Drug, Miscellaneous Supplies/Services and Hospitalization benefits, but not the Travel Assistance benefit.

At the time of a medical emergency, you or someone travelling with you **must** contact Worldwide Assistance Services Inc. before receiving medical care. If contact with Worldwide Assistance cannot be made before services are provided, then it must be made as soon as possible afterwards. If Worldwide Assistance is not contacted, the insurer may deny or limit payments for all expenses related to the emergency services.

Q Do I have to re-enroll in the travel assistance benefit each time I travel?

A No, as long as you are enrolled in the Extended Health Care Plan you are covered for Travel Assistance benefits. Be sure to carry your Medi-Passport Card (issued by the insurance carrier) with you when you travel, for immediate access to the services and coverage. The toll-free telephone numbers are listed on the reverse side of your Medi-Passport Card.

Limitations and Exclusions

There are certain limitations and exclusions under the Extended Health Care Plan. No benefit will be payable for any of the following:

- Where benefits are payable under a Workers' Compensation Act, a similar statute, or any Government agency
- Services and supplies, rendered or prescribed, by a person who is ordinarily a resident in the patient's home, or who is related to the patient by blood or marriage
- Services or products for cosmetic purposes
- Services or products normally rendered without charge
- Services rendered in connection with medical examinations for insurance, school, camp, association, employment, passport, or similar purposes
- Services or charges by a physician, or any other charges, that are covered by a provincial or territorial plan
- Products or treatments considered experimental by the insurance company
- Portion of charges which is the legal liability of any other party

Making Changes

If you waive coverage for your dependents upon your appointment because they have coverage elsewhere (i.e., through a spousal plan), and that coverage subsequently terminates, you have 60 days to apply for coverage under this Benefit Plan. This 60 day limit also applies in the case of acquiring a new dependent. If your application for coverage is received within 60 days, coverage begins on the day following the date that your dependents' comparable coverage terminated, or the date you acquire a new dependent. If your application for coverage is received after 60 days, coverage is effective on the first day of the fourth month following the month in which the application is received.

If you request a change in coverage from Family to Single, the change is effective on the first day of the month following the date the notice of change is received.

Dental Plan

The Dental Plan provides you and your dependents with coverage for dental expenses whether you need a routine check-up once a year or you require more extensive dental work.

Expenses are reimbursed at the levels indicated in the following chart; however, there are certain limitations and exclusions. Once you have paid a $50 deductible ($75 for a family), you are reimbursed by the insurance company for the balance of your costs, up to the limits specified by the Dental Plan, subject to reasonable and customary charges. The deductible does not apply to the Orthodontic services.

Q Why is there a deductible?

A Deductibles are one way of sharing the total cost of benefits between MLAs and the Government of Yukon. Once you have paid the one-time deductible each benefit year (April 1 – March 31), the Government of Yukon then shares the remainder of the cost up to the amount covered by the Dental Plan.

Dental Plan* (single/dependent(s))	Reimbursement level for eligible expenses
Diagnostic/Preventive/Restorative/ Periodontic/Endodontic	• 100% • Up to $1,000 per benefit year per person combined with Denture/Bridge/Crown
Denture/Bridge/Crown	• 50% • Up to $1,000 per benefit year per person combined with Diagnostic/Preventive/ Restorative/Periodontic/Endodontic
Orthodontic	• 50% • Up to $2,000 per dependent child for life

* Some maximums do apply.

What is Covered

The Dental Plan provides reimbursement of eligible expenses based on the applicable dental fee guide in effect, and subject to any maximums or deductibles. Laboratory and anaesthesia procedures must be completed in conjunction with other services.

Q What is a dental fee guide?

A A dental fee guide is a manual, updated regularly by the provincial and territorial dental associations. It outlines the maximum the insurance company will consider as eligible expenses for any particular procedure. Your dentist may charge above the fee guide maximum if he/she wants to; however, only the fee guide maximum will be considered for reimbursement under this Dental Plan.

It is recommended that for any treatment that is expected to cost more than $500, you ask your dentist to submit a dental treatment plan to the insurance company.

Q What is a dental treatment plan?

A A dental treatment plan is a document prepared by your dentist, which outlines the cost of the recommended procedures. The insurance company will calculate the benefits payable for the proposed treatment so you know in advance the portion of the expense you'll have to pay. These treatment plans are typically valid for 90 days from the date of issue.

The Dental Plan covers 100% of diagnostic, preventive, restorative, periodontic and endodontic procedures. Following are some of the procedures covered under each area:

Diagnostic/preventive: Includes examinations and diagnosis, tests, laboratory exams, x-rays, cleanings, space maintainers, laboratory procedures and drug injections.

Restorative: Includes fillings, periodontics (non-surgical treatment of gums), denture repairs and adjustments, denture relining and rebasing, surgical procedures (i.e., uncomplicated removal of teeth), laboratory procedures and anaesthesia.

Periodontic: Includes surgical services related to the treatment of gums (includes x-rays, anaesthesia and laboratory procedures).

Endodontic: Includes root canal therapy and related treatments, anaesthesia and laboratory procedures.

For denture, bridge and crown procedures and orthodontics, the Plan covers 50% of the cost, and includes:

Dentures: Includes partial or complete dentures, remakes and adjustments, examinations and laboratory procedures.

Bridges: Includes fixed bridgework, retainers, repairs and adjustments, examinations, anaesthesia and laboratory procedures.

Crowns: Includes crowns, inlays, onlays, repairs and adjustments, examinations and laboratory procedures.

Orthodontics: Includes observation, adjustment, appliances, comprehensive treatment, anaesthesia, and laboratory procedures. Only covered dependent children under age 19 are eligible for orthodontic procedures, up to a lifetime maximum of $2,000.

Keep in Mind:

The Dental Plan covers 100% of diagnostic, preventive, restorative, periodontic and endodontic procedures and 50% of the cost of dentures, bridge and crown procedures. For all of these benefits, there is a $1,000 per person per benefit year maximum. Orthodontic procedures are reimbursed at 50%, and are limited to a lifetime maximum of $2,000 per dependent child under age 19.

What is Not Covered

The Dental Plan does not cover:

- Charges for appointments not kept
- Charges for completion of claim forms
- Expenses for services rendered prior to the date you became eligible for the benefit
- Expenses for cosmetic services
- Expenses for prosthetic devices ordered while insured, but installed after your benefit coverage terminates
- Expenses for crowns or onlays for teeth not impaired by incisal angle or cuspal damage
- Expenses for permanent splinting
- Expenses for full mouth reconstructions, vertical dimension correction, or for correction of temporomandibular dysfunction
- Expenses for replacement of dentures, crown, inlays, onlay or bridgework within five years of the original installation
- Expenses for replacement of space maintainers, periodontal appliances, orthodontic appliances or dentures which have been lost, stolen or mislaid

Limitations and Exclusions

No benefit is payable for:

- Expenses which are covered under a Workers' Compensation Act, a similar statute, or any Government agency
- Expenses incurred due to intentionally self-inflicted injuries
- Expenses incurred due to civil disorder or war, whether or not war was declared
- Expenses for which benefits are payable under a Government Plan

Making Changes

If you waive coverage for your dependents upon your appointment because they have coverage elsewhere (i.e., through a spousal plan), and that coverage subsequently terminates, you have 60 days to apply for coverage under this Benefit Plan. This 60 day limit also applies in the case of acquiring a new dependent. If your application for coverage is received within 60 days, coverage begins on the day following the date that your dependents' comparable coverage terminated, or the date you acquire a new dependent. If your application for coverage is received after 60 days, coverage is effective on the first day of the fourth month following the month in which the application is received.

If you request a change in coverage from Family to Single, the change is effective on the first day of the month following the date the notice of change is received.

Life Insurance

There are several different life insurance benefits available under the Plan. These benefits are not compulsory; however, all are meant to protect you and your dependents in the event of a death.

The table below outlines each life insurance benefit as well as how much is paid in the event of a death.

Life Insurance	Benefit amount
Basic	• One times annual earnings • Reduces by 50% at age 65
Optional	• One times annual earnings • Reduces by 50% at age 65
Dependent(s)	• Spouse: $5,000 • Each Child: $2,500

Q What is a beneficiary?

A Your beneficiary is the person, or persons, you designate to receive your life insurance benefits in the event of your death. If you wish to update your beneficiary records, contact the Public Service Commission. If you purchase life insurance for your spouse or children, you are their beneficiary and will, therefore, receive the life insurance benefit in the event of their deaths.

Q Why should I appoint a beneficiary?

A If you die and do not designate a beneficiary, it takes longer for the insurance company to settle the life insurance claim. In addition, without a beneficiary designation, the life insurance amount is payable to your estate, unless you have a will in which you specifically indicate how the Government of Yukon Life Insurance proceeds are to be distributed.

Please note that the Life Insurance amount received by your beneficiary(ies) is not subject to income tax. On the other hand, if you have not designated a beneficiary, the life insurance proceeds may be subject to various taxes/fees when paid to your estate, or according to your will if applicable.

Basic Life Insurance

The Benefit Plan covers you for an amount of Basic Life Insurance equal to one times your annual salary, for which you pay the entire premium. In the case of this benefit, it reduces by 50% at age 65.

Keep In Mind:

Keep in mind that the maximum amount of Basic Life Insurance is $500,000 and the maximum amount of Optional Life Insurance is $500,000.

Q How much life insurance do I need?

A In order to answer this question, you want to consider your personal situation by asking yourself these questions:

- Do I have a spouse who works outside of the home?
- Do I have additional coverage somewhere else?
- Do I have extensive financial resources that will provide for my family if I'm injured or die?

If you answered *No* to any of these questions, you may want to carefully consider your level of insurance to ensure that your beneficiaries are protected in the event of your death.

Living Life Insurance Benefit

If you have a terminal illness and death is expected within 24 months, you can request that up to 50% of your Basic Life Insurance benefit, or $100,000, whichever is less, is paid to you. Additional limitations may apply if you are within 5 years of the date your coverage is scheduled to reduce. Proof of your medical condition will be required.

Optional Life Insurance

You may elect additional Optional Life Insurance, for which you pay the entire premium, providing you have enrolled in the Basic Life Insurance Plan. Premiums are based on your age and gender, and are noted in your enrollment package. You can elect to be covered for one times your annual salary. In the case of this benefit, it reduces by 50% at age 65 .

Optional Life Insurance will require *Medical Evidence of Insurability* at the time of enrollment. Coverage is not effective until your application has been received and approved by the insurance company.

Q What is *Medical Evidence of Insurability*?

A *Medical Evidence of Insurability* is proof of your good health. Typically, you fill out a form and answer a number of medical questions to provide proof of your or your dependent's physical condition. Providing medical evidence may be mandatory before your application for coverage is considered.

Dependent Life Insurance

If you have eligible dependents, you may choose to cover them for Dependent Life Insurance, providing you have elected Basic Life Insurance coverage for yourself. Upon the death of your spouse or children, this benefit pays:

- Spouse: $5,000
- Children: $2,500

Life insurance for your children takes effect immediately upon live birth.

Making Changes

You have 60 days to apply for Basic Life Insurance coverage, otherwise coverage will require *Medical Evidence of Insurability*.

If you choose to elect Optional Life Insurance, you are required to submit *Medical Evidence of Insurability*.

You have 60 days to apply for Dependent Life Insurance coverage, otherwise coverage will require *Medical Evidence of Insurability*. This applies if you are covering dependents upon your appointment as an MLA, or if you've acquired a new dependent.

Waiver of Premium

Life Insurance continues and premiums are waived if you become totally disabled before age 65. This provision takes effect once you are eligible for LTD benefits, typically following 13 consecutive weeks of disability.

What happens to my life insurance if I become disabled?

If you become totally disabled before age 65, your Basic, Optional and Dependent Life Insurance may be continued. Premiums will be waived after you have been totally disabled for the length of the qualifying period as per the Long Term Disability (LTD) benefit. Coverage can continue without payment of premiums until you reach age 65 or retire, whichever is earlier.

Conversion Option

At retirement, or when you cease to be an MLA, you can convert your policy to an individual policy without submitting medical evidence if you submit a request to the insurance company and pay the first premium within 31 days after termination of your group insurance.

Limitations and Exclusions

There is a limitation under the Basic and Optional Life Insurance Plan relating to *Waiver of Premium*. If you become disabled due to a condition for which you received medical attention *before* you became insured, the premiums will not be waived.

However, there are exceptions to this limitation. If you work for at least 13 consecutive weeks after becoming insured, with no absence related to this condition, or you become disabled more than 12 months after you became insured, premiums will be waived if you become disabled.

Accidental Death & Dismemberment (AD&D) Insurance

Participation in this benefit is optional. Should you choose to participate, you will be required to specify the number of units of coverage you want, based on the guidelines indicated below. You must elect Basic Life Insurance coverage for yourself in order to participate in the AD&D Plan.

AD&D Insurance is similar to life insurance in that it provides you and your family with additional, optional protection if you are injured or die in an accident. As an eligible MLA, you are covered for up to $250,000 elected in units of $25,000. Your spouse is covered for $5,000, and each eligible child is covered for $2,500. These maximums are known as the ***principal sum***.

Accidental Death & Dismemberment (AD&D) Insurance	Principal Sum
MLA	Units of $25,000 up to a maximum benefit of $250,000
Dependent(s)	Spouse: $5,000 Each Child: $2,500

Q What is a *principal sum*?

A The *principal sum* is the amount you (or your dependents) are covered for under the AD&D Plan; in your case up to a maximum of $250,000.

Q What is the difference between AD&D Insurance and Life Insurance?

A Both types of insurance cover you and/or your dependents in the event of death. However, it is important to note that you will be covered under AD&D Insurance only if the death is the result of an accident. In this case, the AD&D amount is paid in addition to the Life Insurance amount. Life Insurance generally pays a benefit regardless of the cause of death.

What is Covered

Depending on the specific loss, you or your beneficiary will receive all or a portion of the *principal sum*, as follows:

- Loss of life 100%
- Hemiplegia 100%
- Paraplegia..... 100%
- Quadriplegia 100%
- Loss of both hands, both feet or sight of both eyes..... 100%
- Loss of one hand and one foot..... 100%
- Loss of one hand or one foot and sight of one eye..... 100%
- Loss of speech and hearing 100%
- Loss of one arm or one leg..... 75%
- Loss of one hand, one foot or sight of one eye 50%
- Loss of speech or hearing..... 50%
- Loss of thumb and index finger of one hand 25%

If you or your dependents suffer more than one loss, the amount of benefit paid will be the higher of the two losses.

If you or your dependents die in an accident that occurs at least 150 kilometres from home, the AD&D benefit pays up to $10,000 to prepare and transport your remains back to the place of residence.

If you or your dependents suffer any of the losses as a result of being unavoidably exposed to the elements, the AD&D benefit pays for the loss.

If you or your dependents disappear and the body is not recovered after one year and the whereabouts remain unknown for that time, the AD&D benefit pays the amount of benefit for loss of life, assuming:

- There is no indication the insured is alive, and
- The insurance company receives a signed statement from the beneficiary stating that if the insured is found alive, or found dead by means not covered under this provision, the benefit will be repaid.

There are other components of the AD&D benefit for which you may be eligible. Depending on your circumstances, you may be eligible for the following:

Programs and Subsidies

Retraining: If you suffer a loss, and need to be retrained for alternative employment, this benefit will pay up to $10,000 to retrain you in an appropriate occupation within two years of the date of your accident. This benefit does not cover living expenses for room and board, travel or clothing.

Spousal Assistance: If your spouse requires additional training to assist him/her to prepare for active employment following your death due to an accident, the insurance company will pay up to $10,000 within three years of the date of the accident. This benefit does not cover living expenses for room and board, travel or clothing.

Dependent Assistana: You may be able to recover some expenses for your children's education at the lesser of 5% of the principal sum, or $5,000. This benefit can be paid up to four years after your accidental death. To qualify, your child must be enrolled as a full-time student at a post secondary institution at the time of the accident. Alternatively, your child could be a student at the secondary school level and then become enrolled in a post secondary institution within 365 days of the accident. This benefit does not cover living expenses for room and board, travel or clothing.

These programs and subsidies are not available under a Dependent AD&D claim.

Keep in Mind:

If you die or suffer a loss due to an accident, the AD&D benefit also provides several programs and subsidies to help you or your family recover. You may be eligible for the following:

Retraining: Up to $10,000 to retrain you for an alternate occupation
Spousal Assistance: Up to $10,000 to retrain your spouse for active employment
Dependent Assistance: Up to $5,000 for your children's education

These programs and subsidies are available only with a claim for Member AD&D, not Dependent AD&D.

What is Not Covered

No AD&D benefit is payable for a loss due to:

- Suicide, while sane or insane
- Self-inflicted injuries, while sane or insane
- Disease, physical or mental infirmity, or medical or surgical treatment
- Ptomaine or bacterial infections, unless infection is introduced through a visible wound accidentally sustained
- Taking of poison or inhalation of poisonous gases
- Civil disorder or war, whether war is declared or not, unless you are outside of Canada at the direction of the Government of Yukon on a posting assignment or in travel status
- Injuries received while you were operating, learning to operate or serving as a member of a crew of any aircraft
- Injuries received while riding in, on, or boarding an aircraft being used for anything except transportation (i.e., sky diving)

Limitations and Exclusions

This benefit pays out in the case of accidents. If you suffer a loss, the loss must occur within 365 days of the accident. Coverage terminates on the date of retirement, or when you cease to be an MLA, whichever is earlier.

Long Term Disability Insurance

Long Term Disability (LTD)

Participation in this benefit is currently optional; however, participation will become mandatory following the next territorial election. Long Term Disability (LTD) benefits provide income protection if you are sick or injured for an extended period of time. LTD benefits are effective starting after 13 consecutive weeks of disability.

If you become *totally disabled*, a monthly benefit will be paid to you equal to 70% of monthly earnings. The maximum monthly benefit is $11,000.

Long Term Disability (LTD)	Benefit amount
MLA	Effective starting after 13 consecutive weeks of disability 70% of monthly earnings Maximum of $11,000/month

Q What is the *qualifying period*?

A The *qualifying period* related to LTD benefits is the first 13 weeks of your total disability.

Q What does *totally disabled* mean?

A There are two different definitions depending on the time period being considered.

- During the qualifying period and the next two years, you will be considered disabled if you have a medical condition which prevents you from performing the essential functions of your own job.
- After that, you will be considered disabled if you have a medical condition which prevents you from performing the essential functions of any occupation for which you are qualified by training, education or experience if the earnings of that occupation are at least 66 2/3% of your former position.

If you are receiving disability or retirement income from other sources (except any individual disability policy), your monthly benefit through the LTD benefit will be reduced by, and coordinated with, any amount you may be receiving from:

- Canada Pension Plan (CPP), or a similar pension plan (excluding benefits for dependent children)
- Workers' Compensation Plan, or similar statute
- An automobile insurance policy
- Other government or group insurance policies
- Retirement income, and
- Quebec Parental Insurance Plan

The maximum disability and retirement income you can receive from all of the above sources combined with your LTD benefit is 85% of your monthly pre-disability income.

Benefits do increase over time and are based on changes to the Consumer Price Index (CPI). If the CPI increases, you will receive a cost of living adjustment, or COLA. The maximum cost of living adjustment (3%) is applied each January 1st.

Q Are disability payments I receive taxable?

A Yes, benefits you receive will be taxed.

While you are disabled, you must be under the active and continuous care of your physician, and follow the course of treatment prescribed by your physician. The insurance company must consider that your physician is an appropriate choice based on the nature of your condition.

You will be encouraged to return to some type of work whenever possible, and to achieve that, the rehabilitation program offers assessment, counseling, retraining, trial work and part-time or modified work. For the first two years of participation in a rehabilitation program, your benefit will be reduced, but only to the extent that all benefits combined do not exceed your pre-disability income.

Glossary of Terms

Accidental Death & Dismemberment (AD&D) Insurance: Provides a financial benefit for death, dismemberment or loss resulting directly from an accident

Benefit Plan: Refers to the benefits as provided for under the Government of Yukon's *Public Service Group Insurance Benefit Plan* Act

Benefit Year: April 1 to March 31

Conversion Option: An option to transfer a group insurance benefit to an individual plan with the insurance company when you retire or cease to be an MLA.

Coordination of Benefits: A provision that provides reimbursement for expenses when a person is covered by two separate benefit plans, or covered as both an MLA and a dependent under the Government of Yukon's Benefit Plan

Deductible: The dollar amount you must pay prior to reimbursement being made under the Benefit Plan

Dental Fee Guide: A dental fee guide is a manual, updated regularly by the provincial and territorial dental associations. The applicable fee guide is the one in force on the day when and in the province or territory where the expenses are incurred, or, for expenses incurred outside of Canada, in the member's province or territory of residence

Dental Plan: Provides coverage for dental expenses (i.e., routine check-ups or extensive procedures)

Dental Treatment Plan: A document prepared by your dentist and submitted to the insurance company to confirm coverage and reimbursement levels before a dental procedure is started

Dependents: Your spouse, of either sex, either legally married or living common-law for at least one year immediately before application for coverage under the plan; your unmarried dependent children (natural, adopted or stepchild of you or your spouse or a child whom you or your spouse is the legal guardian and guardianship has been court ordered) under age 21, or under age 25 if attending school on a full-time basis; your physically or mentally disabled children who are entirely dependent on you for support and their disability occurred while covered under the Plan as a dependent child

Extended Health Care Plan: Provides coverage for medically-necessary expenses over and above those covered by the Yukon Health Care Insurance Plan

Life Event: Situations that have an impact on the benefit coverage you need, such as: marriage, common-law relationships, birth/adoption of a child, divorce, loss or gain of spouse's employer coverage, or death of a dependent

Life Insurance: Provides protection for you and/or your dependents in the event of a death

Long Term Disability (LTD): Provides income replacement protection if you are unable to work for an extended period of time due to illness or injury

Medical Evidence of Insurability: Proof of good health. Typically, you fill out a form and answer a number of medical questions to provide proof of your or your dependent's physical condition. Providing medical evidence may be mandatory before your application for coverage is considered.

Medically Necessary: Services and supplies generally recognized by the Canadian medical profession as effective, appropriate, and required in the treatment of an illness in accordance with Canadian medical standards.

Member: Refers to the MLA who has enrolled in the Benefit Plan

MLA: Refers to the Member of the Legislative Assembly of the Government of Yukon

Pay Direct Drug Card: A card you use when you want to fill a drug prescription with your pharmacist that allows him/her to process your claim with the insurance company electronically and immediately. This card is only eligible under the Extended Health Care Plan

Principal Sum: A lump-sum payment made upon your accidental death or bodily loss, or your dependent's accidental death or bodily loss

Reasonable and Customary Charges: Charges that the insurance company determines are reasonable and customary and are normally made to people in that area

Travel Assistance Benefit: Provides protection for you and your dependents when you are traveling outside of the Yukon on vacation or business

Waiver of Premium: A provision that allows you to continue benefit coverage without paying premiums, if you become totally disabled

Yukon Health Care Insurance Plan: The mandatory, Government-sponsored health insurance plan that pays for basic medical services for residents of the Yukon

Who to Call

Extended Health Care and Dental Care: Questions about your coverage or claims should be directed to the insurer at 1-800-361-6212 or askus@sunlife.com. Your policy number and ID number will be required. For your convenience, you should register for member access on Sun Life's website at www.sunlife.ca/member.

Accidental Death & Dismemberment, Life Insurance and Long Term Disability: Questions about your coverage or eligibility for benefits should be directed to the Public Service Commission.

Yukon Health Care Insurance Plan: General inquiries at 867-667-5209.